

**Liberty Public School District #53
District Incident Form**

<input type="checkbox"/> Alexander Doniphan	<input type="checkbox"/> Manor Hill	<input type="checkbox"/> Liberty Middle School	<input type="checkbox"/> Support Services Center
<input type="checkbox"/> Franklin	<input type="checkbox"/> Ridgeview	<input type="checkbox"/> South Valley Middle School	<input type="checkbox"/> Kid's Zone
<input type="checkbox"/> Kellybrook	<input type="checkbox"/> Shoal Creek	<input type="checkbox"/> Liberty High School	<input type="checkbox"/> Blue Jay Tower
<input type="checkbox"/> Lewis & Clark	<input type="checkbox"/> Warren Hills	<input type="checkbox"/> Liberty North High School	<input type="checkbox"/> DAC/DAS
<input type="checkbox"/> Liberty Oaks	<input type="checkbox"/> Discovery Middle School	<input type="checkbox"/> Liberty Academy	<input type="checkbox"/> Other
<input type="checkbox"/> Lillian Schumacher	<input type="checkbox"/> Heritage Middle School	<input type="checkbox"/> Early Childhood Center	

Name _____ Age ____ Grade ____ Male ____ Female ____
 Student Volunteer Other _____

Address _____

Parent/Guardian _____ Primary Phone Number _____

Date of Incident _____ Time of Incident _____ Secondary Phone Number _____

Body Part Injured: (Indicate right or left when appropriate)

- | | | | | |
|----------------------------------|---------------------------------|-----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hand | <input type="checkbox"/> Neck | <input type="checkbox"/> Trunk |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Eye | <input type="checkbox"/> Head | <input type="checkbox"/> Nose | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Face | <input type="checkbox"/> Hip | <input type="checkbox"/> Scalp | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Back | <input type="checkbox"/> Finger | <input type="checkbox"/> Internal | <input type="checkbox"/> Shoulder | |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Foot | <input type="checkbox"/> Knee | <input type="checkbox"/> Thumb | |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Groin | <input type="checkbox"/> Leg | <input type="checkbox"/> Toes | |

Type of injury:

- | | | | | |
|---|---|--|--|--------------------------------------|
| <input type="checkbox"/> Bruise/Contusion | <input type="checkbox"/> Bump | <input type="checkbox"/> Foreign Object/Body | <input type="checkbox"/> Orthopedic Trauma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Cut/Laceration | <input type="checkbox"/> Scratch/Abrasion | <input type="checkbox"/> Strain/Twist | |

Action Taken:

- | | | | | | |
|---|--|---|--|---|---|
| <input type="checkbox"/> Kid's Zone stay | <input type="checkbox"/> Parent took to doctor | <input type="checkbox"/> Parent took to ER | <input type="checkbox"/> Parent notified | <input type="checkbox"/> Parent took home | <input type="checkbox"/> Parent took to dentist |
| <input type="checkbox"/> Parent took to urgent care | <input type="checkbox"/> Returned to class | <input type="checkbox"/> Taken to ER by ambulance | <input type="checkbox"/> Other _____ | | |

Explanation of Accident:

As Reported By _____ Witnessed By _____

- | | | | | | | |
|--|--|-------------------------------|--|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Collision with obstacle | <input type="checkbox"/> Collision with person | <input type="checkbox"/> Fall | <input type="checkbox"/> Hit with object | <input type="checkbox"/> Injury to self | <input type="checkbox"/> Trip/Slip | <input type="checkbox"/> Other _____ |
|--|--|-------------------------------|--|---|------------------------------------|--------------------------------------|

Location of Accident: Before School During School After School

- | | | | | |
|--|------------------------------------|---|---|--------------------------------------|
| <input type="checkbox"/> Bus | <input type="checkbox"/> Classroom | <input type="checkbox"/> Off Campus | <input type="checkbox"/> Restroom | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bus Parking Lot | <input type="checkbox"/> Gymnasium | <input type="checkbox"/> Playground | <input type="checkbox"/> School Parking Lot | |
| <input type="checkbox"/> Cafeteria | <input type="checkbox"/> Hallway | <input type="checkbox"/> Prior Injury at Home | <input type="checkbox"/> Stairs | |

Describe specifically how the injury happened _____

Assessment comments _____

Injured treated by: Nurse Teacher Kid's Zone Other _____

Signature _____

Follow-Up: Date: _____ Outcome: _____

Parent Signature (Kid's Zone Only) _____ Date _____

Principal/Director Signature _____ Date _____

District Administration Signature _____ Date _____



LIBERTY PUBLIC SCHOOLS
STUDENT OR PATRON INCIDENT - SUPERVISOR INVESTIGATION REPORT FORM

Supervisors are required to conduct a thorough investigation of incidents resulting in injuries or illness. This form is to be completed by the supervisor to accompany the completed LPS Student/Patron Incident Report Form. Send this form attached to the Student/Patron Incident Report Form to the Director of Health Services.

Student/Patron Name:		Date of Incident:
Employee Responsible for Supervision of Student/Patron:		
Supervising Employee Job Title:		Location of Incident:
Building:	Department:	Incident Report Form Completed (list date signed by principal/director):
Was the employee using approved methods in supervision/performing a duty at the time of the injury?		
If mechanical equipment was involved, was the student/patron trained in use of equipment and/or procedures related to performing the intended function?		
Did the student/patron commit an unsafe act? <input type="checkbox"/> No <input type="checkbox"/> Yes; If corrective action was taken please document here		
If additional information is discovered pertaining to the incident other than what is documented on the Student/Patron Incident Report Form, please detail below. Attach an additional page if necessary and or drawing.		
Check one or more factors that may have contributed to the incident/injury:		
Task Related:	<input type="checkbox"/> Hazardous procedures used	<input type="checkbox"/> Inadequate personal protective equipment
	<input type="checkbox"/> Improper position or posture	<input type="checkbox"/> Incorrect, defective or unavailable tools
Material/Equip:	<input type="checkbox"/> Inadequate guarding	<input type="checkbox"/> Unsafe design or construction
Environment:	<input type="checkbox"/> Poor weather conditions	<input type="checkbox"/> Inadequate lighting/ventilation
	<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Poor workstation layout
Personal:	<input type="checkbox"/> Inexperience of person	<input type="checkbox"/> Lack of training
	<input type="checkbox"/> Unusual stress	<input type="checkbox"/> Operating without authority
Organization:	<input type="checkbox"/> Inadequate maintenance	<input type="checkbox"/> Lack of safety procedures
	<input type="checkbox"/> Inadequate supervision	<input type="checkbox"/> Lack of safety inspection
Student:	<input type="checkbox"/> Special needs / behavioral	<input type="checkbox"/> Elementary student
	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Secondary student
Other: (explain)		
Briefly describe the action taken to investigate the incident and the steps taken to prevent a recurrence.		
Check one or more actions taken or planned to prevent a recurrence:		
<input type="checkbox"/> Repair or replace tool or equipment	<input type="checkbox"/> Improve personal protective equipment	
<input type="checkbox"/> Install safety device	<input type="checkbox"/> Provide, update, or develop training Specify type of training: _____ If playground injury, review SafeSchools training	
<input type="checkbox"/> Revise or develop a procedure	<input type="checkbox"/> Provide closer supervision	
<input type="checkbox"/> Improve preventative maintenance program	<input type="checkbox"/> Improve housekeeping	
<input type="checkbox"/> Complete disciplinary action	<input type="checkbox"/> Other (explain)	
<input type="checkbox"/> Work Order submitted for identified need	<input type="checkbox"/> Work Order number if available: _____	

Investigated by Supervisor: _____ Date: _____

Name and Signature

Print Name

PROCEDURE FOR EMPLOYEES WHEN A WORK-RELATED INCIDENT OCCURS

Reporting: Report the injury to your supervisor as soon as possible and complete the Employee Incident Report Form. Your supervisor will have this form. Your supervisor will review and sign the form.

If immediate or urgent care is needed, it is suggested that you go to the WorkHealth Solutions Clinic. Your supervisor must initiate authorization. The clinic is located at 9151 NE 81st Terrace, Kansas City, MO 64158. The phone number is **(816) 407-2300** and the fax number is **(816)407-2301**. The clinic hours are from 8:00am to 5:00pm, Monday - Friday.

You do not need an appointment to access medical care at the Work Health Solutions, however appointments are recommended. Tell them that you are an employee of Liberty Public Schools and provide the Treatment Authorization form. They will have you complete the necessary forms to initiate your workers' compensation claim. If you need care after hours, please go to Liberty Hospital.

Returning to Work: You cannot return to work without a release from a physician.

After you have been treated at the hospital or clinic, you will be given a form that discusses your work status. You must provide your supervisor with a copy of this form as soon as possible, but no later than your next regularly scheduled work day. If you are unable to perform the duties of your regular job, every effort will be made to temporarily modify your job so it is compatible with your physical capabilities.

Bills: You should not get any bills or be asked to pay anything out of **pocket if your workers' compensation claim is accepted**. If you receive any bills or incur any out of pocket expenses, please send to the Risk Management Department at the District Administrative Center.

Contact Information: If you have any questions or concerns about the workers' compensation process or your claim, please contact your immediate supervisor. They will redirect you if necessary based on your questions.



Case # _____
(To be completed by Risk Manager)

**LIBERTY PUBLIC SCHOOLS
EMPLOYEE INCIDENT REPORT FORM**

The supervisor is responsible to ensure this report is completed when a work related incident or injury occurs. If the employee is unable to complete their portion of this form, the supervisor must complete the form on their behalf. Incident reporting ensures there is a record on file with the employer. If the employee needs and/or request examination or treatment by a medical provider, the supervisor must complete the WorkHealth Solutions Authorization for Medical Treatment and immediately notify the Risk Manager at 736-6712.

Please Print

EMPLOYEE INFORMATION – TO BE COMPLETED BY EMPLOYEE

1. Employee Name		2. Home Mailing Address		3. City/State/Zip	
4. Home Phone Number	5. Job Title		6. # Days per week you work?	7. Time Began Work:	8. Time Stopped Work:
9. Date of Incident	10. Time of Incident	11. Date Reported to Supervisor	12. Building		13. Department
14. Specific Location of Incident(example: hallway outside classroom 205)				15. Name of Witnesses: First and Last Name	
16. Did the incident happen in the normal course of work? <input type="checkbox"/> Yes <input type="checkbox"/> No				Complete Witness Form	
17. How did the incident occur? Describe the activity and any tools, equipment, or material you were using (example: I was opening a box of books using scissors. The scissors slipped and cut my right finger.)					
18. What were you doing prior to the incident?					
19. List the body part(s) injured:(right finger)			20. Type of Injury: (Example: bruise)		
In case of Back Strain or Abdominal Regions, Items 21 and 22 must be answered.					
21. Approx. weight of object handled	22. How high was it lifted?	23. Is this kind of work performed regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No; if no, why this time?			
24. Were you subject to unusual strain or circumstances? <input type="checkbox"/> No <input type="checkbox"/> Yes: if yes explain:			25. Did you slip, fall or strike yourself? <input type="checkbox"/> No <input type="checkbox"/> Yes; if yes explain:		
26. How do you think this type of Incident can be prevented? (please explain)					
27. Are you / Did you receive medical treatment? <input type="checkbox"/> Reporting Only (No treatment Needed) <input type="checkbox"/> I decline treatment at this time <input type="checkbox"/> Treatment was provided <input type="checkbox"/> Treatment will be sought <input type="checkbox"/> Transported self for treatment <input type="checkbox"/> Transported by ambulance for treatment					
Employee Signature		Print Name		Date	

SUPERVISOR INFORMATION – TO BE COMPLETED BY THE IMMEDIATE SUPERVISOR

Please rate this incident: Probable Recurrence Rate Frequent Occasional Rare

I have investigated this incident and agree that the injury did occur while the employee was on duty and as he/she described above. Furthermore, I will complete the incident investigation report form

Supervisor's Signature _____ Print Name _____ Date Report Completed _____

NURSE INFORMATION – TO BE COMPLETED BY THE NURSEPlease sign/date here →

If First Aid Treatment was provided, please describe:

Risk Manager's Comments & Recommendations: _____
RM Signature/Date: _____



**LIBERTY PUBLIC SCHOOLS
SUPERVISOR INCIDENT INVESTIGATION REPORT FORM**

Supervisors are required to conduct a thorough investigation of incidents resulting in injuries or illness. This form is to be completed by the supervisor in addition to the LPS Incident Report Form RM201-LPS. Send this form to the Risk Manager within 2 days of the incident.

Employee Name:		Date of Incident:
Job Title:		Location of Incident:
Building:	Department:	Incident Report Form Completed:

Was the employee using approved methods in performing a duty at the time of the injury?

If mechanical equipment was involved, was the employee trained in use of equipment and/or procedures related to job functions?

Did the employee commit an unsafe act? No Yes; If corrective action was taken send documents to Risk Manager

Was the employee using approved methods in performing a duty at the time of the injury?

Briefly describe the events leading to the incident or injury, what was being done at the time, describe the injury and what actually happened, and include a description of any equipment or machinery involved. Attach an additional page if necessary and or drawing.

Check one or more factors that may have contributed to the incident/injury:

Task Related:	<input type="checkbox"/> Hazardous procedures used	<input type="checkbox"/> Inadequate Personal Protective Equipment
	<input type="checkbox"/> Improper position or posture	<input type="checkbox"/> Incorrect, defective or unavailable tools
Material/Equip:	<input type="checkbox"/> Inadequate guarding	<input type="checkbox"/> Unsafe design or construction
Environment	<input type="checkbox"/> Poor weather conditions	<input type="checkbox"/> Inadequate lighting/ventilation
	<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Poor workstation layout
Personal:	<input type="checkbox"/> Inexperience of person	<input type="checkbox"/> Lack of training
	<input type="checkbox"/> Unusual stress	<input type="checkbox"/> Operating without authority
Organization:	<input type="checkbox"/> Inadequate maintenance	<input type="checkbox"/> Lack of safety procedures
	<input type="checkbox"/> Inadequate supervision	<input type="checkbox"/> Lack of safety inspection
Student:	<input type="checkbox"/> Special needs / behavioral	<input type="checkbox"/> Elementary student
	<input type="checkbox"/> Student / violent behavioral	<input type="checkbox"/> Secondary student
Other: (explain)		

Briefly describe the action taken to investigate the incident and the steps taken to prevent a recurrence.

Check one or more actions taken or planned to prevent a recurrence:

<input type="checkbox"/> Repair or replace tool or equipment	<input type="checkbox"/> Improve personal protective equipment
<input type="checkbox"/> Install safety device	<input type="checkbox"/> Provide, update, or develop training
<input type="checkbox"/> Revise or develop a procedure	<input type="checkbox"/> Provide closer supervision
<input type="checkbox"/> Improve preventative maintenance program	<input type="checkbox"/> Improve housekeeping
<input type="checkbox"/> Complete disciplinary action	<input type="checkbox"/> Other (explain)

Investigated by Supervisor: _____ Date: _____
Name and Signature

Print Name

**LIBERTY PUBLIC SCHOOLS
WITNESS STATEMENT FORM**

Send this form to the Risk Manager within 24 hours of the incident.

INJURED WORKER

Injured Employee Name:	Date of Incident:
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WITNESS DETAILS

Name:	Phone Number:
Relationship to the injured worker: Co-worker Supervisor By-stander Other _____	
Please specify	

INCIDENT DETAILS

Type of injury(e.g. burn, cut, fracture)	
Location of injury:	Time of injury:
CHECK APPLICABLE BOX:	
I observed the incident and it occurred in the following manner:	
I did not observe the accident; however, information given to me by:	
I have no knowledge of the occurrence	

Any person who fraudulently obtains or fraudulently attempts to obtain any benefit by malingering or making any false claim or statement, and any person who, by a false statement or other means, aids or abets a person in so obtaining or attempting to obtain, commits an offense.

I declare that the details submitted are true and correct.

Signature of Witness: _____ Date: _____
Name and Signature

RM Use Only:
Claim # _____

RM205-LPS-0907

Liberty Public Schools

Workers' Compensation Verification of Receipt

I have received the following forms concerning my work-related Injury/Illness.

Please check (✓)

<input type="checkbox"/> Employee Statement of Incident <input type="checkbox"/> Medical Treatment Authorization <input type="checkbox"/> Employee Procedures <input type="checkbox"/> Facts For Injured Workers <input type="checkbox"/> Verification of Receipt	
Seeking Treatment:	
<input type="checkbox"/> No – Not seeking treatment at this time	<input type="checkbox"/> Yes –If so, Treatment Authorization must be completed and signed by employee supervisor or authorized personnel.

I understand if I have any questions, seek treatment, or miss anytime related to this claim I will contact my immediate supervisor.

Signature

Date

Print Name

Bldg



TREATMENT AUTHORIZATION

Employee: _____

S.S.#: _____ DOB: _____

Date of Injury: _____

Type of Injury: _____

Body Part(s) Involved: _____

Employer: _____

SERVICE(S) REQUESTED:	
Drug Screens	Physicals
<input type="checkbox"/> Pre-Employment	<input type="checkbox"/> Post Offer
<input type="checkbox"/> Random	<input type="checkbox"/> DOT Exam
<input type="checkbox"/> Reasonable Cause	<input type="checkbox"/> DOT Recertification
<input type="checkbox"/> Post-Accident	
<input type="checkbox"/> DOT	Injury Care
<input type="checkbox"/> Non-DOT	<input type="checkbox"/> Evaluate/Treat
Alcohol Screen	<input type="checkbox"/> Emergency Room Follow-up
<input type="checkbox"/> Breath Alcohol	<input type="checkbox"/> Blood/Body Fluid Exposure
<input type="checkbox"/> Non-DOT	
<input type="checkbox"/> DOT	

Appointment Date & Time: _____

Comments: _____

 Authorized Signature

 Title

 Date

 (Office Use)

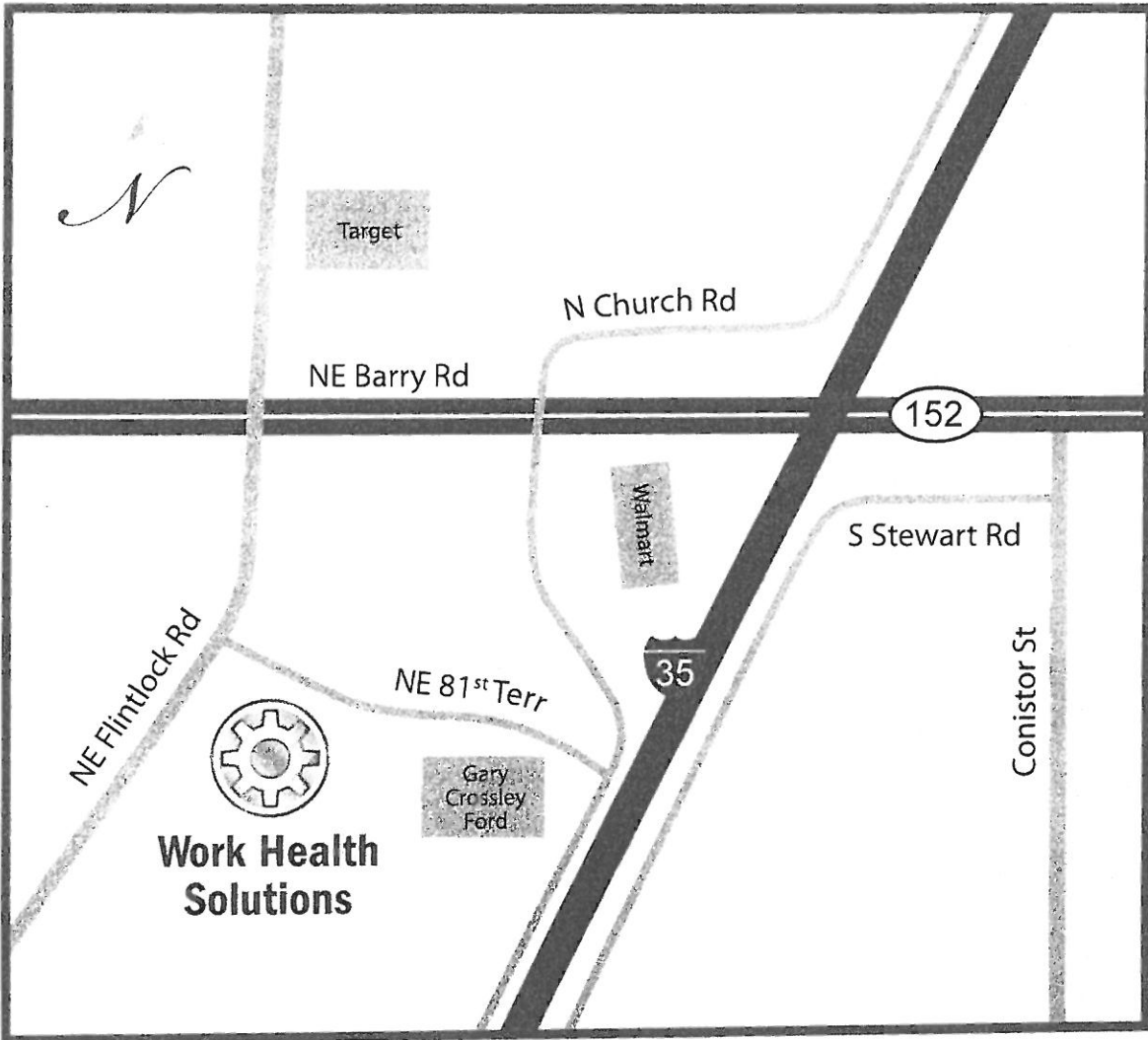


WORK HEALTH SOLUTIONS

A Service of Liberty Hospital

9151 NE 81st Terrace, Suite 200, Kansas City, MO 64158 • Phone (816) 407-2300

Your appointment is _____



Work Health Solutions is located at 9151 NE 81st Terrace, Suite 200, behind Gary Crossley Ford. From Highway 152, go south on either Flintlock Road or Church Road to 81st Terrace. We are located on the second floor.

When Must The Claim Be Filed?

If you decide to file a claim, the Division must receive the claim:

1. Within two years after the date of the injury or, if payment was made on account of your workers' compensation injury, within two years after the last benefit payment made; or
2. If the employer does not timely file a report of injury with the Division, within three (3) years from the date of injury or death, or last payment was made on account of the injury or death.

Where Can I Get More Information?

Ask your employer or the workers' compensation claims representative of the employer's insurer. The name, address, and telephone number of the insurer or claims administrator must be posted at the workplace. You can also talk to an information specialist at the Division of Workers' Compensation. For additional information about the dispute management service, filing a claim, or other workers' compensation questions, please call toll-free:

1-800-775-2667

Where Are The Division Offices?

3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058
(573) 751-4231
TDD Users Call Relay
MO. 1-800-735-2966

3102 Blattner Dr., Suite 101
Cape Girardeau, MO 63703-6348
(573) 290-5757

3311 Texas Avenue
Joplin, MO 64804-4343
(417) 629-3032

1805 Grand Avenue, Suite 400
Kansas City, MO 64108-1840
(816) 889-2481

1736 East Sunshine, Suite 610
Springfield, MO 65804-1333
(417) 888-4100

3737 Harry S. Truman Blvd., Suite 300
St. Charles, MO 63301-4096
(636) 940-3326

525 Jules St., Room 315
St. Joseph, MO 64501-1900
(816) 387-2275

111 N. Seventh St., Room 250
St. Louis, MO 63101-2170
(314) 340-6865

The Division of Workers' Compensation does not discriminate against individuals with disabilities as mandated by PL 101-336, the Americans with Disabilities Act. This brochure is available in Spanish, upon request.

Fraudulent action on the part of an employer, employee, or any other person, is unlawful and subject to punishment as provided by law. If you suspect fraud, contact Division of Workers' Compensation offices, or call the Fraud and Noncompliance Unit at 1-800-592-6003.

Missouri Division of Workers' Compensation
P.O. Box 58
Jefferson City, MO 65102-0058

Facts For Injured Workers



Missouri Department of
Labor and Industrial Relations
DIVISION OF
WORKERS' COMPENSATION

Introduction

This is a summary of the general provisions of the Missouri Workers' Compensation Law including the changes made to the law that became effective August 28, 2005. For additional information, contact an information specialist at the Division of Workers' Compensation at 1-800-775-2667. This pamphlet is not a complete statement of the workers' compensation law. It should not be relied on to answer your legal questions. The workers' compensation statutes will apply to determine the facts regarding your injury.

Hurt On The Job?

A work-related injury is a traumatic experience. If you are injured on the job or become ill as a result of your employment, the Missouri Workers' Compensation program can provide some relief from the worry and financial strain of being injured and possibly off work due to an injury.

Missouri law requires most employers to carry insurance, which pays for medical treatment and lost time benefits for employees who are injured on the job. The law requires prompt payment of benefits at no cost to you if you sustain a work-related injury covered under the law.

Who Is Covered?

If you are employed in the construction industry, your employer must have workers' compensation insurance, if the employer has one or more employees. Employers in other types of business must carry insurance if they have five or more employees. Railroad, postal, and maritime workers are covered by federal laws.

The Missouri Workers' Compensation Law does not apply to employment of farm labor, domestic servants in a private home, occasional labor performed for a private household, qualified real estate agents and direct sellers, certain unpaid volunteers, certain inmates, and certain individuals working for amateur youth programs.

www.dolir.mo.gov/nc

What Is Covered?

All injuries and occupational diseases must meet the standard of work being "the prevailing factor" in causing the injury or disease and the injury must arise out of and in the course of employment. Idiopathic injuries that result from an unknown cause are not covered. Certain injuries that occur when the employee is going to and from work are excluded.

What Do I Do If I Am Injured?

Report the injury immediately to your employer or supervisor and provide information about the injury – what, where, when, and how it happened. Your employer or supervisor should arrange medical treatment and file the necessary reports with the Division. Prompt reporting is the key. Insure your right to benefits by a written notice of every injury, no matter how slight.

Failure to report your injury to your employer may jeopardize your ability to receive workers' compensation benefits. To assure your right to benefits for which you may be eligible, notify your employer of the injury in writing within 30 days.

What Are The Benefits?

Missouri law provides three kinds of workers' compensation benefits:

- ♦ **Medical care to treat the injury** – All costs for authorized medical testing and treatment, prescriptions and medical devices are covered. There is no deductible and all costs are paid by your employer or its workers' compensation insurance company. If you do receive a bill, contact your employer or insurer immediately.

- ♦ **The employer or the insurer, on behalf of the employer, has the right to choose the healthcare provider.** The employer and insurer are not required to pay for treatment the employee seeks or selects without their authorization. However, the employer and insurer may authorize you to see your own doctor. You should check with the

www.dolir.mo.gov/nc

employer and insurance company with respect to any medical treatment you seek.

- ♦ **When an employee is required to submit to treatment at a place outside of the local or metropolitan area from the employee's principal place of employment, the employer is entitled to payment for necessary and reasonable expenses.** In no event is the employer or insurer required to pay transportation costs of more than 250 miles each way from the place of treatment.

- ♦ **In addition, the employer/insurer may offer physical rehabilitation services to assist you in returning to work.** This is an extension of medical treatment – for example, physical therapy to strengthen muscles.

- ♦ **Payments for lost wages** – Most injuries only keep you from working temporarily and you may be eligible for temporary total disability payments until the doctor says you are able to return to any form of employment and not merely the job you were doing at the time of accident. If you return to work on light duty at less than full pay, you may be eligible for temporary partial disability payments.

- ♦ **Compensation for permanent disability** – Once a doctor has determined that you have reached maximum medical improvement (you are as well as you can be), and that you have a permanent disability, you may be entitled to receive a permanent disability payment. If the disability is less than total disability, you receive a lump sum settlement based upon the extent of the disability. The law contains guidelines to determine the amount of payment. If the disability is permanent total disability, you may receive case payments for life or a lump sum settlement.

How Much Are The Benefit Payments?

- ♦ **The benefits provided for temporary total disability are calculated at sixty-six and two-thirds percent (66 2/3 percent) of the injured worker's average weekly wage, not to exceed a maximum amount set by law.** This is determined based on your gross wages (your pay before taxes).

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- ♦ **Compensation is not paid for the first three days you are unable to work.** If you are unable to work for more than 14 days, the "three-day waiting period" is paid.

- ♦ **If you suffer from a permanent partial disability, you may receive a lump sum payment based upon the amount of disability.**

- ♦ **If you are permanently and totally disabled you may receive periodic payments or a lump sum settlement.** The amount of the payment is based upon the amount of your earnings at the time of the injury.

- ♦ **Disability payments and medical bills are paid by your employer's workers' compensation insurance.** If a medical bill is not paid or you do not receive a disability check in a timely manner, contact your employer and insurer.
- ♦ **Workers' compensation payments are tax-free.**

What If There Is A Problem?

If you think you have not received all benefits due you, contact your employer or the insurance company.

If the problem cannot be resolved, you may wish to take advantage of the dispute management service provided by the Division of Workers' Compensation, have a conference before an administrative law judge, or you may wish to file a Claim for Compensation.

The dispute management service is a voluntary informal process to help the parties arrive at a resolution to the problem. For additional information call (573) 526-4931, toll-free for injured employees 1-800-775-2667, or toll-free for employers (888) 837-6069.

To appear before an administrative law judge, please contact the Workers' Compensation office nearest you or visit the Division's web site.

If you wish to file a claim with the Division of Workers' Compensation, a Claim for Compensation (Form WC-21) must be used. This form may be obtained at any office of the Division of Workers' Compensation or on the web site at www.dolir.mo.gov/nc.

For additional information about a settlement, filing a claim or other workers' compensation questions, please call 1-800-775-2667.

WC-101-2 (01-06) AI